EXTERNAL REVIEW APPLICATION FORM

Request for Independent External Appeal of a Denied Medical Claim

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Section I – Applicant Information

Patient's Name:_____ Patient's Date of Birth: _____

Applicant's Name:_____ Applicant's Email: _____

Applicant's Mailing Address: _____

City:_____ State:_____ Zip Code: _____

Applicant's Phone Number(s): Daytime: (_____)_____ Evening: (_____)_____

Section II – Appointment of Authorized Representative

** Complete this section only if someone else is representing the patient in this appeal **

You may represent yourself or you may ask another person, including your treating health care Provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize_____ to pursue my appeal on my behalf.

_____ _____

Signature of Patient (or legal representative – Please specify relationship or title) Date

Representative's Mailing Address: _____

City:_____ State:_____ Zip Code: _____

Representative's Phone Number(s): Daytime: (_____)_____ Evening: (_____)_____

Section III - Insurance Plan Information

Member's Name:_____Insurance ID #:_____

Health Insurance Company's Name: _____

Insurance Company's Mailing Address: _____

City:_____State:_____Zip Code: _____

Insurance Company's Phone Number: (_____) _____

Is the member's insurance plan provided by an employer? Yes_____No _____

Name of employer: _____

Employer's Phone Number: (_____) _____

Is the employer's insurance plan self-funded? Yes*_____No _____

*If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review through the Bureau of Insurance. Please contact us for further information.

Section IV – Information about the Patient's Health Care Providers

Name of Treating Health Care Provider: _____

Provider's clinical specialty: _____

Treating Provider's Mailing Address: _____

City:_____State:_____Zip Code: _____

Treating Provider's Phone Number: (_____) _____

*If you have more than one treating provider that you would like to have participate in the external review hearing, please attach a separate sheet listing their name, specialty, contact information and times available for the hearing

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Section V – Health Care Decision in Dispute

Describe the health insurance company's decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree.

Please attach the following:

☐ Additional pages, if necessary.

☐ A copy of the Health Insurance Company's letter denying the requested treatment or service at the final level of the company's internal appeals process.

☐ If possible, a statement from the treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

Section VI – Expedited Review

** Complete this section, only if you would like to request expedited review **

The patient or appointed representative may request that the external review be handled on an expedited basis. To qualify for an expedited review, the delay must seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function. Expedited external review is not available when services have already been rendered.

Do you request an expedited review? Yes_____No _____

Applications for Expedited External Review may be faxed to (207)624-8599, emailed to Sandra.Giles@maine.gov or sent by overnight carrier to the address on the top of this form.

Section VII – Request for a Hearing

** Complete this section, only if you would like to request a telephone hearing **

If the patient, the authorized representative or the treating health care provider would like to discuss this case with the Independent Review Organization and the insurer in a telephone conference, select "Yes" below.

Do you request a telephone hearing? Yes_____No ____

Is your provider participating in the telephone hearing? Yes___No____

*If yes, please provide the provider's contact information and times available for the hearing:

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VIII – Authorization and Release of Medical Records

I hereby authorize that any hospital, physician, insurance carrier or insurance carrier subcontractor, or any entity regulated by the Maine Bureau of Insurance may furnish the Bureau and the Independent Review Organization (IRO) assigned to review the insurance carrier's adverse health care treatment decision with any medical information or records that may be required to conduct the external review. I specifically authorize the release of information concerning mental health, and substance abuse treatment if that information is needed to conduct the external review.

_____ _____

Signature of Patient (or legal representative – Please specify relationship or title) Date

Before submitting this application, please verify that you have …

☐Completed all relevant sections of the External Review Application Form

☐If requesting a telephone hearing, Section VII must be completed.

☐Signed and dated the External Review Application Form in Section VIII.

The time frame for receiving a decision from an IRO for a standard external review is up to 30 days.

Expedited external review is available only if adherence to the time frame for standard review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The time frame for receiving a decision from an IRO for an expedited external review is within 72 hours without a hearing.